		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035485

Facility Name: Swann Special Care Center

Address: 109 Kenwood Road (Number) Champaign (City) 61821 (Zip Code)

County: Champaign

Telephone Number: (217) 356-5164 **Fax #** (217) 356-7873

IDPA ID Number: 31-1262572

Date of Initial License for Current Owners: 08/15/89

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501 (c) (3)		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: James R. Johnson **Telephone Number:** (859) 255-0075

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/01 to 06/30/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) James R. Johnson
(Title) V.P. of Finance - Jefferson Medical Rehab. Centers, Inc.

Paid Preparer

(Signed) See Compilation Report (Date)
(Print Name and Title) Robert A. Thomas, Partner
(Firm Name & Address) Thomas Healthcare Consulting, P.C., 11711 Meridian Street, Suite 725, Carmel, IN 46032
(Telephone) (317) 580-8301 Fax # (317) 580-8310

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2	112	Skilled Pediatric (SNF/PED)	112	40,880	2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	112	TOTALS	112	40,880	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED	37,192	472		37,664	9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	37,192	472		37,664	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.13%

D. How many bed-hold days during this year were paid by Public Aid?
756 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 08/15/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 08/15/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL	MODIFIED CASH*	CASH*
[X]	[ ]	[ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	194,167	15,778	11,505	221,450		221,450	(79,167)	142,283			1
2	Food Purchase		240,988		240,988		240,988		240,988			2
3	Housekeeping		21,459	111,939	133,398		133,398		133,398			3
4	Laundry	29,189	16,812	87,963	133,964		133,964		133,964			4
5	Heat and Other Utilities			87,327	87,327		87,327		87,327			5
6	Maintenance	63,236	20,625	58,440	142,301		142,301		142,301			6
7	Other (specify):*											7
8	**TOTAL General Services**	286,592	315,662	357,174	959,428		959,428	(79,167)	880,261			8
	B. Health Care and Programs											
9	Medical Director			28,800	28,800		28,800		28,800			9
10	Nursing and Medical Records	2,677,090	173,376	87,034	2,937,500	(9,046)	2,928,454		2,928,454			10
10a	Therapy	29,594	4,060	115,846	149,500		149,500		149,500			10a
11	Activities	126,849	3,169	470	130,488		130,488		130,488			11
12	Social Services	978	697	2,302	3,977		3,977		3,977			12
13	Nurse Aide Training											13
14	Program Transportation		6,138	3,083	9,221	(220)	9,001		9,001			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,834,511	187,440	237,535	3,259,486	(9,266)	3,250,220		3,250,220			16
	C. General Administration											
17	Administrative	53,263		148,794	202,057	(148,343)	53,714	(451)	53,263			17
18	Directors Fees					9,076	9,076		9,076			18
19	Professional Services			463,375	463,375	46,993	510,368		510,368			19
20	Dues, Fees, Subscriptions & Promotions			15,174	15,174	376	15,550	(4,869)	10,681			20
21	Clerical & General Office Expenses	124,986	25,240	18,791	169,017	35,740	204,757	(3,053)	201,704			21
22	Employee Benefits & Payroll Taxes			1,030,958	1,030,958	5,089	1,036,047		1,036,047			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,914	14,914	10,832	25,746	(1,846)	23,900			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			32,930	32,930		32,930		32,930			26
27	Other (specify):* **Bad Debt**			34,300	34,300		34,300	(34,300)				27
28	**TOTAL General Administration**	178,249	25,240	1,759,236	1,962,725	(40,237)	1,922,488	(44,519)	1,877,969			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,299,352	528,342	2,353,945	6,181,639	(49,503)	6,132,136	(123,686)	6,008,450			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Swann Special Care Center #0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			179,671	179,671	116	179,787		179,787			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			426,720	426,720	49,565	476,285	(31,242)	445,043			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			11,584	11,584	(178)	11,406		11,406			35
36	Other (specify):* **Amortization**			38,383	38,383		38,383	(27,835)	10,548			36
37	**TOTAL Ownership**			656,358	656,358	49,503	705,861	(59,077)	646,784			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			4,733	4,733		4,733		4,733			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			337,056	337,056		337,056		337,056			42
43	Other (specify):* **Edu/Day Training**	835,188	23,305	280,757	1,139,250		1,139,250		1,139,250			43
44	**TOTAL Special Cost Centers**	835,188	23,305	622,546	1,481,039		1,481,039		1,481,039			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,134,540	551,647	3,632,849	8,319,036		8,319,036	(182,763)	8,136,273			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(31,242)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(34,300)	27		24
25	Fund Raising, Advertising and Promotional	(4,674)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(624)	21		28
29	Other-Attach Schedule	(111,472)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (182,312)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(451)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (451)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (182,763)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39		X		SNF/PED		39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Swann Special Care Center

ID# 0035485

Report Period Beginning: 07/01/01

Ending: 06/30/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	School Lunch Reimbursement	$ (79,167)	1	1
2	Goodwill Amortization	(27,835)	36	2
3	Non-Allowable Travel	(1,696)	24	3
4	Non-Allowable Seminar	(150)	24	4
5	Chamber of Commerce	(195)	20	5
6	Miscellaneous Income	(2,429)	21	6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(111,472)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Swann Special Care Center # 0035485 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(79,167)	0	0	0	0	0	0	0	0	0	0	(79,167)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(79,167)	0	0	0	0	0	0	0	0	0	0	(79,167)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(451)	0	0	0	0	0	0	0	0	0	(451)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(4,869)	0	0	0	0	0	0	0	0	0	0	(4,869)	20
21	Clerical & General Office Expenses	(3,053)	0	0	0	0	0	0	0	0	0	0	(3,053)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,846)	0	0	0	0	0	0	0	0	0	0	(1,846)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(34,300)	0	0	0	0	0	0	0	0	0	0	(34,300)	27
28	**TOTAL General Administration**	(44,068)	(451)	0	0	0	0	0	0	0	0	0	(44,519)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(123,235)	(451)	0	0	0	0	0	0	0	0	0	(123,686)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Swann Special Care Center # 0035485 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(31,242)	0	0	0	0	0	0	0	0	0	0	(31,242)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	(27,835)	0	0	0	0	0	0	0	0	0	0	(27,835)	36
37	**TOTAL Ownership**	(59,077)	0	0	0	0	0	0	0	0	0	0	(59,077)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(182,312)	(451)	0	0	0	0	0	0	0	0	0	(182,763)	45

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		Exceptional Care & Training Center	Sterling			
		Walter Lawson Children's Home	Loves Park			
		Vernon Manor Children's Home	Wabash, Indiana			
		Richland-Bean Blossom HCC	Ellettsville, Indiana			
		Hanover Nursing Center	Hanover, Indiana			
		Clay County Nursing Center	Brazil, Indiana			
		Randolph Nursing Home	Winchester, Indiana			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Corporate Expenses	$ 148,794	Hoosier Care, Inc.	100.00%	$ 148,343	$ (451)	1
2	V								2
3	V				Note: See schedule VIII of allocation of cost per column 7.				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 148,794			$ 148,343	$ * (451)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bruce Hutson, M.D.	Director	Board Meetings	0.00	7,508			Director Fees	$ 1,815	18.8	1
2	Stephen Wood	Director	Board Meetings	0.00	7,508			Director Fees	1,815	18.8	2
3	John Gillmor	Director	Board Meetings	0.00	7,508			Director Fees	1,815	18.8	3
4	John Foos	Director	Board Meetings	0.00	7,508			Director Fees	1,815	18.8	4
5	Michael Conn	Director	Board Meetings	0.00	7,507			Director Fees	1,816	18.8	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 9,076		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Hoosier Care, Inc.
Street Address: 535 West Second, Suite 105
City / State / Zip Code: Lexington, KY 40508
Phone Number: (859) 255-0075
Fax Number: (859) 281-5150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Director's Fees	Revenue	40,133,041	8	$ 46,615	$ 0	7,814,228	$ 9,076	1
2	19	Professional Fees	Revenue	40,133,041	8	241,351	0	7,814,228	46,993	2
3	20	Fees,Subscription & Promotion	Revenue	40,133,041	8	923	0	7,814,228	180	3
4	21	Clerical & General Office Exp.	Revenue	40,133,041	8	183,702	0	7,814,228	35,768	4
5	22	Emp. Benefits & Payroll Tax	Revenue	40,133,041	8	26,136	0	7,814,228	5,089	5
6	24	Travel & Seminar	Revenue	40,133,041	8	7,990	0	7,814,228	1,556	6
7	30	Depreciation	Revenue	40,133,041	8	597	0	7,814,228	116	7
8	32	Interest Expense	Revenue	40,133,041	8	254,560	0	7,814,228	49,565	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 761,874	$		$ 148,343	25

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Ill. Health Financing Authority		X	Purchase of Facility	Varies	07/08/99	$ 5,710,000	$ 5,590,000	06/01/2034	7.1250	$ 400,514	1
2	Ill. Health Financing Authority		X	Purchase of Facility	Varies	07/08/99	260,000	245,000	06/01/2019	10.5000	26,206	2
3												3
4												4
5												5
	Working Capital											
6	Home Office Allocation										49,565	6
7												7
8												8
9	TOTAL Facility Related						$ 5,970,000	$ 5,835,000			$ 476,285	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 5,970,000	$ 5,835,000			$ 476,285	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Swann Special Care Center **#** 0035485 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997	None	8
1998		9
1999		10
2000		11
2001		12

Note: The facility became exempt from property taxes starting 1/1/96.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Swann Special Care Center COUNTY Champaign

FACILITY IDPH LICENSE NUMBER 0035485

CONTACT PERSON REGARDING THIS REPORT James R. Johnson

TELEPHONE (859) 255-0075 FAX #: (859) 281-5150

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Not Applicable		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,257 B. General Construction Type: Exterior Block & Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF/PED	89,603	1989	$ 538,000	1
2					2
3	TOTALS	89,603		$ 538,000	3

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	87		1989	1975	$ 2,592,000	$ 56,275	10-40	$ 56,275	$	$ 1,067,885	4
5	9			1993	319,955	10,665	30	10,665		118,524	5
6	8			1996	N/A		N/A				6
7	8			2000	157,933	5,264	30	5,264		9,213	7
8											8
	Improvement Type**										
9	Paint & Panels			1989	1,308		3			1,308	9
10	Blinds			1990	384		3			384	10
11	Fire Doors			1990	2,751		10			2,751	11
12	Storm Windows			1991	4,224		10			4,224	12
13	Fire Doors			1991	3,675		10			3,675	13
14	Compressor			1991	1,035		10			1,035	14
15	Carpeting			1991	220		10			220	15
16	Sprinkler & Fire Alarm			1991	695	11	10	11		695	16
17	Sprinkler			1992	3,162	158	10	158		3,162	17
18	Damper			1992	674	39	10	39		674	18
19	Fire Alarm System			1992	1,945	114	10	114		1,945	19
20	Water Heater			1992	1,998		7			1,998	20
21	Roofing			1992	3,900	390	10	390		3,738	21
22	Voltage Relay			1993	1,875	188	10	188		1,784	22
23	Sprinkler System			1993	14,460	1,446	10	1,446		13,496	23
24	Wall Covering			1993	3,190	319	10	319		2,924	24
25	Wall Papering			1993	3,000	300	10	300		2,725	25
26	Blinds with Valance			1993	2,395	240	10	240		2,159	26
27	Carpet and Rubber Base			1993	2,848	285	10	285		2,564	27
28	Replace Siding			1993	575	57	10	57		510	28
29	Remodeling in Team Rooms			1993	9,405	941	10	941		8,233	29
30	Plexiglas for Doors & Walls			1993	714	71	10	71		622	30
31	Resurface Parking Lot			1993	19,115	1,911	10	1,911		16,563	31
32	Shed			1993	5,990	599	10	599		5,341	32
33	Stain New Shed			1993	1,248	125	10	125		1,104	33
34	Fire Doors, Closets, Tile			1993	5,225	522	10	522		4,525	34
35	Architectural Renovation			1993	855	85	10	85		731	35
36	Install Alarm & Nurse Call			1994	688	69	10	69		574	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Heat Pump	1994	$ 2,017	$ 202	10	$ 202	$	$ 1,649	37
38	Paving for New Sign	1994	680	68	10	68		550	38
39	Labor for Laying Brick - Sign	1994	1,000	100	10	100		808	39
40	Sign for Dedication	1994	325	32	10	32		260	40
41	Sign and Granite Pieces	1994	1,300	130	10	130		1,051	41
42	Material for Leasehold Improvements	1995	7,858		3			7,858	42
43	Hoods, Fans, Ansul System	1995	2,500	250	10	250		1,833	43
44	Work for Exhaust Fan & Hood	1995	3,995	399	10	399		2,893	44
45	Day Room Addition	1995	3,337	334	10	334		2,366	45
46	Replace Water Heater	1995	3,750	375	10	375		2,656	46
47	Day Room Additional Supplies	1995	1,926	193	10	193		1,367	47
48	Walk-in-Cooler	1995	3,334	333	10	333		2,248	48
49	Nurse Call System	1996	1,198	120	10	120		760	49
50	Shed	1996	2,034	203	10	203		1,269	50
51	Air Conditioner Compressor	1996	1,208	121	10	121		736	51
52	Supplies for Leasehold Improvements	1996	3,091		3			3,091	52
53	Building Addition - Materials & Labor - 1,500 Square Feet Multi-Purpose								53
54	Activity Room & Bathroom Addition plus renovation								54
55	to the Dental Office	1996	180,928	9,046	20	9,046		56,538	55
56	Construct Screens, Wheelchairs	1996	1,420		3			1,420	56
57	Construct Shelving, Beds, Screen	1996	2,964		3			2,964	57
58	Install Nurse Call System	1996	1,530	153	10	153		918	58
59	Tile Flooring & Adhesive	1996	1,227	123	10	123		717	59
60	Linoleum Flooring	1996	686	69	10	69		391	60
61	Install New Drain Pipes	1996	2,190	219	10	219		1,241	61
62	Remove Concrete to Replace Drain Pipes	1996	575	58	10	58		328	62
63	Install Exit Door Hardware	1997	874	87	10	87		471	63
64	Day Training Improvement	1997	4,078	513	4	513		4,078	64
65	Install New Disposal	1997	1,069	107	10	107		508	65
66	Replace Four-Door Glass	1998	520	52	10	52		225	66
67	Remove / Replace Underground Fuel Tank	1998	9,223	461	20	461		1,690	67
68	Remodel Project 2410 Springfield	1998	33,764	8,441	4	8,441		30,247	68
69	Partition Wall Kitchen / Dinning Area	1998	595	74	8	74		265	69
70	TOTAL (lines 4 thru 69)		$ 3,448,638	$ 102,337		$ 102,337	$	$ 1,418,682	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,448,638	$ 102,337		$ 102,337	$	$ 1,418,682	1
2	Replace Two Roof-Top HVAC Units-Wings I&II	1998	17,650	1,765	10	1,765		6,325	2
3	Replace Vent Damper Assembly - Hot Water Heater	1998	740	74	10	74		265	3
4	Convert Two Classrooms into Resident Rooms	1998	15,258	1,526	10	1,526		5,468	4
5	Security Door and Hardware - Converted Rooms	1999	520	52	10	52		178	5
6	Remove / Replace Hot Water Heater - Resident Area	1999	3,000	300	10	300		950	6
7	Replace Combustion Motor/Fan on Heater - West Wing	1999	1,155	116	10	116		377	7
8	Electrical Service Move Switches	1999	141	18	8	18		61	8
9	Installation of Water Heaters	1999	595	60	10	60		190	9
10	Resurface Parking Lot	1999	2,350	157	15	157		458	10
11	14 Almond FRP Panel Dividers	1999	513	103	5	103		300	11
12	Install Alarm System	2000	2,000	400	5	400		833	12
13	Install Alarm System	2000	2,730	546	5	546		1,138	13
14	Replaced Compressor on Freezer	1999	635	63	10	63		179	14
15	Replace Grout, Base, and Tile for Bathroom Floors	1999	594	40	15	40		113	15
16	Replaced Bracket / Filter Head, Brushes, Relay on Generator	1999	2,782	278	10	278		765	16
17	Storage Barn	1999	120	5	25	5		14	17
18	Storage Barn	1999	1,045	42	25	42		115	18
19	Replaced Wall Heat Pump Unit	1999	1,525	153	10	153		420	19
20	New Mixing / Tempering Valve for Hot Water	2000	629	63	10	63		157	20
21	Replace Timer / Starter on Emergency Generator	2000	2,153	215	10	215		538	21
22	Install Interior Retrofit Energy Efficient Lighting	2000	15,090	755	20	755		1,762	22
23	Intstall Clinical Sink	2000	3,030	606	5	606		1,212	23
24	Stoneybrook Remodeling PR	2000	138,235	27,647	5	27,647		48,382	24
25	Install Doors at Kenwood	2000	4,028	269	15	269		538	25
26	Replace Gate Valve	2000	6,005	400	15	400		734	26
27	Replace Ceiling Tile	2000	674	67	10	67		123	27
28	Materials to Tile Bathroom	2001	784	78	10	78		124	28
29	Install Booster Pump	2001	1,995	133	15	133		199	29
30	Install Tile in Bathroom	2001	825	55	15	55		82	30
31	New Floor Drains In Shower	2001	3,180	212	15	212		318	31
32	Replace Reversing Valve	2001	599	60	10	60		70	32
33	Replacement Parts for Roof	2001	662	66	10	66		77	33
34	TOTAL (lines 1 thru 33)		$ 3,679,880	$ 138,661		$ 138,661	$	$ 1,491,147	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,679,880	$ 138,661		$ 138,661	$	$ 1,491,147	1
2	Tile for Bathroom	2001	1,854	185	10	185		200	2
3	Stoneybrook Awning	2001	15,560	3,112	5	3,112		4,668	3
4	Stoneybrook Telephone System	2001	1,668	334	5	334		501	4
5	Comp. Ed. Room at Stoneybrook	2001	2,431	486	5	486		729	5
6	Stoneybrook Shelves - Inst	2001	516	103	5	103		146	6
7	Remodeling	2001	8,351	1,392	5	1,392		1,392	7
8	Sprinkler System Renovation	2001	760	51	15	51		51	8
9	Install Shower Drains	2001	10,500	525	20	525		525	9
10	Tile to Repalce Tubs	2001	1,278	85	15	85		85	10
11	Rewired and Replaced Compressor / HVAC	2001	1,404	129	10	129		129	11
12	Replace Laundry Panel	2001	1,179	59	15	59		59	12
13	Valve-Water Heater	2001	876	66	10	66		66	13
14	Internet Set-up Wiring Cable	2002	6,141	171	15	171		171	14
15	Thermostats with Locking Guards	2002	1,371	15	15	15		15	15
16	Classroom Remodel	2002	5,978	199	10	199		199	16
17	Replace Fencing Around Dumpster Area	2002	674	11	10	11		11	17
18	Replace Doors	2002	3,000	300	5	300		300	18
19	Security System	2002	3,165	264	5	264		264	19
20	Remodeling	2002	8,351	557	5	557		557	20
21	Electrical Labor-Remodeling	2002	1,425	95	5	95		95	21
22	Install Two Sinks	2002	3,561	25	5	25		25	22
23	Revise Sprinkler System	2002	501	119	5	119		119	23
24	Rounding		1	(1)		(1)		(5)	24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,760,425	$ 146,943		$ 146,943	$	$ 1,501,449	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 129,517	$ 21,133	$ 21,133	$		$ 70,127	71
72	Current Year Purchases	28,997	3,001	3,001			3,001	72
73	Fully Depreciated Assets	450,899	1,422	1,422			450,899	73
74	Corporate Allocation		116	116				74
75	TOTALS	$ 609,413	$ 25,672	$ 25,672	$		$ 524,027	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1985 GMC Bus	1993	$ 16,250	$	$	$	4	$ 16,250	76
77	Patient Transportation	1985 GMC Bus	N/A	4,041				3	4,041	77
78	Patient Transportation	1989 Ford Mini Bus	1998	3,000	600	600		5	2,250	78
79	See Attached			37,449	6,572	6,572		4-5	13,292	79
80	TOTALS			$ 60,740	$ 7,172	$ 7,172	$		$ 35,833	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,968,578	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,787	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 179,787	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,061,309	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,406 Description: See Attached Schedule
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Swann Special Care Center **#** 0035485 **Report Period Beginning:** 07/01/01 **Ending:** 06/30/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 6,286	$	1
2	Cash-Patient Deposits	98,061		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 87,500)	1,993,170		3
4	Supply Inventory (priced at Cost)	44,286		4
5	Short-Term Investments			5
6	Prepaid Insurance	(219,149)		6
7	Other Prepaid Expenses	3,086		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from Corporate	(5,834,110)		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ (3,908,370)	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	538,000		13
14	Buildings, at Historical Cost	3,760,425		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	670,153		16
17	Accumulated Depreciation (book methods)	(2,061,309)		17
18	Deferred Charges	337,525		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	2,552		21
22	Other Long-Term Assets (specify):	599,984		22
23	Other(specify): Goodwill	753,875		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 4,601,205	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 692,835	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 71,469	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	98,061		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	144,957		30
31	Accrued Taxes Payable (excluding real estate taxes)	63,524		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	35,334		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 413,345	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable	5,835,000		41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 5,835,000	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,248,345	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,555,510)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 692,835	$	48

***(See instructions.)**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (5,081,942)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (5,081,942)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(473,566)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Rounding**	(2)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (473,568)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,555,510)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,118,584	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,118,584	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	8,647	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,647	8
	C. Other Operating Revenue		
9	Payments for Education	685,472	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 685,472	23
	D. Non-Operating Revenue		
24	Contributions	20,340	24
25	Interest and Other Investment Income***	31,242	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 51,582	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	DMH Day Training	892,718	28
28a	See Attached	88,467	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 981,185	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,845,470	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	959,428	31
32	Health Care	3,259,486	32
33	General Administration	1,962,725	33
	B. Capital Expense		
34	Ownership	656,358	34
	C. Ancillary Expense		
35	Special Cost Centers	1,143,983	35
36	Provider Participation Fee	337,056	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,319,036	40
41	**Income before Income Taxes (line 30 minus line 40)****	(473,566)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (473,566)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	486	486	$ 11,058	$ 22.75	1
2	Assistant Director of Nursing					2
3	Registered Nurses	35,352	38,964	757,657	19.45	3
4	Licensed Practical Nurses	4,460	4,707	71,820	15.26	4
5	Nurse Aides & Orderlies	148,702	161,733	1,836,555	11.36	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	1,596	1,629	29,594	18.17	7
8	Rehab/Therapy Aides					8
9	Activity Director	2,030	2,094	29,668	14.17	9
10	Activity Assistants	12,653	13,387	97,181	7.26	10
11	Social Service Workers	23	23	978	42.52	11
12	Dietician					12
13	Food Service Supervisor	2,031	2,102	35,674	16.97	13
14	Head Cook	8,220	8,882	106,920	12.04	14
15	Cook Helpers/Assistants	2,163	2,299	25,211	10.97	15
16	Dishwashers	2,083	2,268	26,362	11.62	16
17	Maintenance Workers	4,411	4,598	63,236	13.75	17
18	Housekeepers					18
19	Laundry	2,000	2,233	29,189	13.07	19
20	Administrator	1,980	2,086	53,263	25.53	20
21	Assistant Administrator					21
22	Other Administrative	1,841	1,981	21,472	10.84	22
23	Office Manager					23
24	Clerical	5,619	6,057	103,514	17.09	24
25	Vocational Instruction					25
26	Academic Instruction	25,920	27,563	364,031	13.21	26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)	857	918	9,190	10.01	28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Day Training	35,539	37,750	461,967	12.24	33
34	TOTAL (lines 1 - 33)	297,966	321,760	$ 4,134,540 *	$ 12.85	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	352	$ 11,451	1.3	35
36	Medical Director	384	28,800	9.3	36
37	Medical Records Consultant				37
38	Nurse Consultant	1,482	69,620	10.3	38
39	Pharmacist Consultant	192	900	10.3	39
40	Physical Therapy Consultant	27	1,080	10a.3	40
41	Occupational Therapy Consultant	901	41,458	10a.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	1,229	67,568	10a.3	43
44	Activity Consultant	12	470	11.3	44
45	Social Service Consultant				45
46	Other(specify) Dental Fees	N/A	4,881	10.3	46
47	Utilization Review	43	1,924	10.3	47
48	See Attached	24,764	304,524		48
49	TOTAL (lines 35 - 48)	29,386	$ 532,676		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Max Redmond	Administrator	0	$ 12,099
Mary Lou Bedient	Administrator	0	41,164
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 53,263

B. Administrative - Other

Description	Amount
Corporate Expenses	$ 148,794
TOTAL (agree to Schedule V, line 17, col. 3)	$ 148,794
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Jefferson Medical Rehabilitation		$
Centers, Inc.	Management Fees	421,200
Katz, Sapper & Miller, LLP	Accounting Fees	3,725
INS Filing Fees	Other Fees	10,070
EMC Trust INS Filing Fees	Other Fees	12,590
Duane, Morris, & Hechscher	Legal Fees	9,686
Alan Carmer Attorney INS Fees	Other Fees	4,400
Hensley Law Office	Legal Fees	630
Miscellaneous INS Fees	Other Fees	1,074
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 463,375

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 382,162
Unemployment Compensation Insurance	21,865
FICA Taxes	304,562
Employee Health Insurance	297,987
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	24,382
Corporate Allocation	5,089
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,036,047

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
None		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	878
(Indicate # of checks performed 82)	
Illinois Health Care Assoc.	4,877
Council for Exceptional Children	104
Public Relations	8,731
Corporate Allocation	180
Chamber of Commerce	195
Other Fees (See Attached)	585
Less: Public Relations Expense	(4,674)
Non-allowable advertising	(195)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,681

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 731
Non-Allowable Out-of-State	(731)
In-State Travel	17,652
Seminar Expense	4,692
Corporate Allocation	1,556
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 23,900

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Not Applicable		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Swann Special Care Center # 0035485 Report Period Beginning: 07/01/01 Ending: 06/30/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **See Schedule XIX, Section F**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **10,135** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **337,056**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **79,167**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? Yes
Indicate the amount of income earned from providing such transportation during this reporting period. $ **30,527**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PriceWaterhouseCoopers** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.